IDAHO DEPARTMENT OF
HEALTH & WELFARE

PARTICIPANT-COMMUNITY SUPPORT WORKER EMPLOYMENT AGREEMENT

This agreement is hereby made between_____, a Participant of the Self Directed Community Supports (SDCS) Option, a Medicaid Option administered by the Department of Health and Welfare (Department),

and_____, a Community Support Worker (CSW).

The Participant desires to engage CSW for services under the SDCS Option. In exchange, the CSW desires to be paid for services provided to the Participant. Both parties understand and agree that payment is made through a fiscal employer agent (FEA), using Medicaid monies and based on time sheets submitted by the CSW and approved by the Participant.

To these mutual purposes, the parties promise and agree as follows:

1. CSW services are to be provided in accordance with the Participant's SDCS Support and Spending Plan, and the SDCS rules, outlined in IDAPA 16.03.13, "Consumer-Directed Services."

2. It is mutually understood that CSW is the employee of the Participant, and that the Participant directs, controls and approves the CSW's work.

3. The CSW is hired to assist the Participant and assumes no legal liability for the Participant's conduct.

4. The CSW promises that he/she meets the following minimum qualifications to be a CSW, as outlined in Section 136 of IDAPA 16.03.13, "Consumer-Directed Services."

5. The parties mutually agree that CSW is an employee of the Participant and is not an employee of the SDCS Option or the Fiscal Employer Agent (FEA), and agree that the CSW is not entitled to nor will make claim for any employee benefits from the SDCS Option or the FEA, including but not limited to, worker's compensation, disability, life or health insurance.

6. The CSW agrees to notify the Participant immediately in the event he/she is unable to provide the agreed services due to sickness, injury or personal emergency. The CSW must obtain the Participant's written approval in advance for any pre-planned absence.

7. The Participant shall train the CSW on the duties and responsibilities of the CSW and shall be responsible for approving the accuracy of CSW's time records.

8. The CSW agrees to provide services in a safe, courteous and professional manner. The CSW acknowledges that any physical, sexual or mental abuse or neglect of the Participant by

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the CSW will result in the immediate termination of this Agreement and a report being made according to the requirements in Section 39-5303, Idaho Code.

9. The CSW agrees to report any observed physical, sexual or mental abuse, exploitation or neglect of Participant to adult protection authorities immediately.

10. The CSW understands and agrees that they cannot provide or bill for services until:

- an authorized Support and Spending Plan has been submitted to the FEA,
- the signed Employment Agreement has been submitted to the FEA
- the signed Medicaid-CSW Agreement has been submitted to the FEA

11. The CSW understands and agrees that no payment for services will be made until both the CSW and the Participant have signed the appropriate time sheets, acknowledging their accuracy, and have submitted them to the FEA.

12. It is mutually understood that Medicaid funding can only pay for services rendered. Under the Self Direction Waiver option, the CSW will not receive payment for any vacation time, holiday time, overtime or sick time. Medicaid will not pay wages at an hourly amount in excess of this agreement.

More than forty (40) hours per week of paid work are allowed only if the CSW meets the criteria for employees that are exempted from overtime pay and minimum wage requirements as per the Fair Labor Standards Act.

The participant must obtain and follow guidance from the Idaho Department of Labor and Commerce to determine if the CSW is exempt from these requirements. It is the responsibility of the participant to ensure that the CSW is exempt if the participant requires the CSW to work more than forty (40) hours per week.

The CSW will be paid only for the specific services authorized as per the Support and Spending Plan.

The signing of this Employment Agreement by the participant and the CSW signifies that the parties acknowledge that the criteria for exemption from overtime and minimum wage requirements will be met prior to scheduling work hours in excess of forty (40) hours per week or agreeing to wages less than minimum wage standards.

COLUMN A	B	C		D		E
Service needed	**Type of Support** ☑ only one box	Number of hours per year OR Number of miles/year		Wage per hour OR Wage per mile		Annual Cost
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement		X		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement ☐ **Code for second rate of pay/hour** ______ **Fill in code**		X		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement ☐ **Code for second rate of pay/hour** ______ **Fill in code** ☐ **Code for third rate of pay/hour** ______ **Fill in code**		X		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement ☐ **Code for second rate of pay/hour** ______ **Fill in code** ☐ **Code for third rate of pay/hour** ______ **Fill in code**		X		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement ☐ **Code for second rate of pay/hour** ______ **Fill in code** ☐ **Code for third rate of pay/hour** ______ **Fill in code**		X		=	$ Sub-Total

	☐ Personal PSS ☐ Job JSS ☐ Transportation TSS ☐ Learning LSS ☐ **Code for second rate of pay/hour** ☐ **Code for third rate of pay/hour**	☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS ☐ Transportation Mileage Reimbursement _____ **Fill in code** _____ **Fill in code**		x		=	$ Sub-Total
	Total Cost of Agreement:						$

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14. The CSW must meet the following specific qualifications in order to provide the following services including attaching copy of certification/licensure, if applicable, as outlined in IDAPA 16.03.13 Subsections 120.05 and 110.03:

_____

_____

_____

_____

_____

15. The Community Support Worker (CSW) agrees to take all actions necessary to become Participant's employee, and to maintain the employment relationship by submitting necessary documents to the FEA, including:

- Completion of W-4, I-9 and other IRS required forms;
- A completed criminal history check, including clearance in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks";
    - **The CSW will list the Department as the agency/employer, using identification number 1710.**
- A copy of this agreement; and
- Time sheets approved by Participant recording hours worked.

The provisions of this agreement represent the entirety of the agreement between the parties. It may be amended only in writing with both parties consenting by their signatures. It is mutually understood that this is employment at will. Either party may terminate the employment relationship without cause upon two weeks notice. This agreement may be terminated at any time by the Participant due to unsatisfactory CSW performance.

PARTICIPANT Date

LEGAL GUARDIAN (IF APPLICABLE) Date

CSW Date

- Unless the Criminal History Background Check is Waived, the Community Support Worker has applied for a Criminal History Background Check through the Department of Health and Welfare. The CSW will list the Department as the agency/employer using the identification number 1710.

The CSW gives permission to the fiscal employer agent to notify the Participant (Employer) of the results of the Criminal History Background Check. _____ CSW Signature.

☐ I am waiving the Criminal History Check requirement. I have completed the attached Waiver of Liability form. I understand that even if CHC is waived the CSW cannot receive Medicaid dollars if he is on a federal or state Medicaid exclusion list.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Criminal History Check
Waiver of Liability - Assumption of Risk

Participant Name: _____ **MID #** _____ **Date:** _____

Waiver: I do not want (name of community support worker) _____ to be subject to Criminal History Check requirements.

Relationship to the Participant: _____

Description of Service: _____

Reason: _____

_____

_____

I Will Make Sure I am Healthy and Safe by: _____

_____

Release of Liability means that I am giving up my right to sue the Department of Health and Welfare or make them pay for any costs associated with things such damages, liabilities, and attorney fees that happen because of my choice.

Assumption of Risk means that I understand that there things such as personal injury, property loss, abuse, neglect and exploitation that could happen in my life as a result of my choice even if I try to prevent them from happening.

I have read the definitions above and have talked to my Support Broker and/or Circle of Support and I understand the risks of what could happen if I decide not to make the provider of my Self-Directed services have a Criminal History Check. I agree that my choice is voluntary and that I knowingly assume all such risks.

_____ _____

Signature of Individual Date Signature of Legal Guardian (if applicable) Date

I have provided education and counseling to _____ regarding the risks of waiving a criminal history check for this individual.

Comments:

_____

_____

Signature of Support Broker Date

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

Criminal History Check
Waiver of Liability - Assumption of Risk – Failed Criminal History Check

Participant Name: _____ **MID #** _____ **Date:** _____

Waiver: I choose to hire (name of community support worker) _____ as my community support worker. I understand that they have failed the criminal history check per requirements at IDAPA 15.05.06, "Rules Governing Mandatory Criminal History Checks".

Relationship to the Participant: _____

Description of Service: _____

Reason: _____

_____

_____

I Will Make Sure I am Healthy and Safe by: _____

_____

_____

Release of Liability means that I am giving up my right to sue the Department of Health and Welfare or make them pay for any costs associated with things such damages, liabilities, and attorney fees that happen because of my choice.

Assumption of Risk means that I understand that there things such as personal injury, property loss, abuse, neglect and exploitation that could happen in my life as a result of my choice even if I try to prevent them from happening.

I have read the definitions above and have talked to my Support Broker and/or Circle of Support and I understand the risks of what could happen if I decide to hire a provider of my Self-Directed services who has a criminal history that would be precluded from providing services in the Idaho Medicaid program. I agree that my choice is voluntary and that I knowingly assume all such risks.

_____ _____

Signature of Individual Date Signature of Legal Guardian (if applicable) Date

I have provided education and counseling to _____ **regarding the risks of waiving a criminal history check for this individual.**

Comments:

_____

_____

Signature of Support Broker Date

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